Kentucky Board of Medical Licensure

310 Whittington Parkway, Suite 1B
Louisville, KY 40222
502/429-7150
www.kbml.ky.gov

TO: Applicant for Physician Assistant Certification

FROM: Sandy K. Brooks, Physician Assistant Coordinator

RE: Application for Physician Assistant Certification

Attached is an application for certification as a Physician Assistant in the Commonwealth of Kentucky. Instructions for completing the application are as follows:

1. Completed application must be **signed and notarized**. Please note that the Board publishes your certification information on our website. This information is used for verification purposes. Please indicate your practice address on the application. If no practice address is listed, your mailing address will be published.

2. Recent original photograph of yourself **(passport size) signed and dated**.

3. FORM 1 – Release and Waiver of Rights, **signed and notarized**.

4. FORM 2 – National Commission on Certification of Physician Assistants Waiver – complete top of form and mail to this Board.

5. FORM 3 – Verification of Certification – send this form to any state in which you currently hold or have ever held a Physician Assistant certification/license.

6. FORM 4 – Certification of Training – send this form to your school for certification of your degree as a physician assistant.

7. Copy of current physician assistant certification wallet card from the NCCPA.

8. Initial application from KY primary supervising physician **and** alternate agreement form.

9. Fees - $100 from the physician assistant and $100 from the primary supervising physician.

Please keep in mind that completion of the application is your responsibility. Only completed applications will be considered by the Committee. If the Committee determines that you have met the statutory requirements for certification, your application will be presented to the Kentucky Board of Medical Licensure for final approval. Incomplete applications will be returned to the applicant. Should you have any questions concerning your application, please contact this office at (502) 429-7150.

FAXES WILL NOT BE ACCEPTED

Kentucky Board of Medical Licensure

310 Whittington Parkway, Suite 1B
Louisville, KY 40222
(502) 429-7150

Application for Certification of Physician Assistant

(Please Type or Print)

Note: Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization. You must answer "yes" to any question if the event(s) described in that question has actually occurred. You must answer "yes" in such circumstances even if you have been advised by an attorney or other person that you may answer "no". You must also answer "yes" in such circumstance even if the record of the event has been sealed or expunged by Court order, or has been designated "confidential" by the body involved. After answering "yes" to the appropriate question(s), you may advise the Board of any additional relevant information pertaining to your answer (i.e., record has been sealed or expunged, record is designated "confidential," attorney has advised that you properly answer "no"). The Board will consider this additional information, along with your answer(s), in determining the appropriate action. If you have any question about whether or not you should answer "yes" to a question, you should err in favor of answering "yes" and provide an explanation, because any non-disclosure violation will likely result in denial of your application or disciplinary action against your certification.

1. Name _____
   (first) (middle) (last)

2. Mailing Address: _____
   (street) (city) (state) (zip)

   *Practice Address: _____
   (street) (city) (state) (zip)

   ***The practice address will be published on the Board's website for your physician assistant profile.**

3. Phone (work) _____ (home) _____

4. Place of Birth _____

5. Date of Birth: _____ 6. Social Security No. _____ - _____ - _____

7. Post – Secondary Educational Training:

   Program and Location Dates (From - To)

   _____

   Course of Study: _____

8. Was the above program accredited by the Accreditation Review Commission on Education For Physician Assistants?
   YES ☐ NO ☐

9. National Commission on Certification of Physician Assistants

   Certificate # _____ Issue Date _____ Expiration _____

10. In what states or provinces have you applied for or been granted certification/licensure as a Physician Assistant? If more than two, attach separate listing. If certificate not issued, so state.

    (a) _____
    (State Board) (Certificate #) (Date Issued)

    (b) _____
    (State Board) (Certificate #) (Date Issued)

Name: _____ Social Security Number: _____

11. EMPLOYMENT HISTORY -Beginning with the most recent, attach additional sheets if necessary to include all PA employment

    Dates: From - To _____ Position Held _____

    Name of Supervising Physician _____

    Business Address _____

    Type of Practice _____ Phone _____

    List Duties Performed in Practice _____

    _____

    _____

12. Have you had any certificate, license, registration or other privilege to practice as a health care professional, denied, revoked, suspended, probated, or restricted by a State or Federal authority, or have you ever surrendered such credential to avoid or in connection with disciplinary investigation/action by such jurisdiction? ☐ **Yes** ☐ **No**

13. Have you been convicted of a felony or misdemeanor by any State or Federal court? Are any criminal charges presently pending against you in any of those courts? ☐ **Yes** ☐ **No**

14. Have you been or are you currently under investigation by any State, Federal or certification/licensure authority or any drug licensure/enforcement authority? ☐ **Yes** ☐ **No**

15. Are any legal proceedings regarding certification/licensure presently pending against you by any State or Federal certification/licensure authority or any drug licensure/enforcement authority? ☐ **Yes** ☐ **No**

16. Have you been removed, suspended, expelled, or disciplined by any professional medical association or society? ☐ **Yes** ☐ **No**

17. Are you currently in default on any student loan repayment obligations payable to financial aid programs administered by the Kentucky Higher Education Assistance Authority? ☐ **Yes** ☐ **No**

If you answer "***YES***" to questions (# 12 - 17), please submit a detailed report of the situation including any charge; date of such charge; the complete name and address of all bodies of jurisdiction; the results of any hearings; and the disposition of such charges on a separate sheet.

I Attest That:

A. I will not perform job duties and scope of medical services and procedures that have not been delegated to me by my supervising physician.

B. I will not prescribe or dispense controlled substances.

C. I will inform all patients I come in contact with of my status as a physician assistant.

D. I will wear identification that clearly states that I am a physician assistant.

Name: _____ Social Security Number:_____

AFFIDAVIT OF APPLICANT: Hereby state that the information contained in this application is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of certification. I authorize the board or its agents to obtain from other sources any information necessary for determining my qualification for certification. I also authorize them to furnish any information they may how or in the future have concerning my qualifications and fitness to act as a physician assistant to any person, institution, association, school, hospital or governmental entity. I understand any false information on my application may subject my certification to disciplinary action pursuant to the Kentucky Certified Physician Assistant Statutes and Regulations.

_____ _____
Signature of Applicant Date

Seal of Notary

Subscribed and sworn to before me by the above named applicant on this _____ day of _____, 20_____. This application consists of 5 pages.

_____
Signature of Notary

My commission expires: _____

*This Application is in Compliance with the American Disabilities Act
(Revised 8/26/99, 7/10/00, 5/21/02, 11/13/02, 7/7/03, 10/7/03, 4/7/05)

Name _____ Social Security Number _____

Physician's Verification

I, _____ affirm that the above applicant *currently works as a physician assistant under my supervision **or**, will be employed under my supervision* and that all of the information contained in this application, including the employment history is true and accurate to the best of my knowledge and belief.

_____ _____ _____
Physician's Signature Date KY License #

Seal of Notary

Subscribed and sworn to before me by the above named applicant this _____ day of _____, 20_____. This application consists of 5 pages.

_____
Signature of Notary

My commission expires: _____

Name _____ Social Security Number _____

The answers to these questions are exempt from public disclosure under KRS 61.878(1)(a) and (I) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answers to these questions may be considered by the Board (KBML) and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a certification decision based upon them.

"Illegal drug use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the direction of the licensed health care professional who prescribed the controlled substance or dangerous drug.

1. Do you currently, or have you had within the past 5 years, any physical, mental, or emotional condition which impaired, or might reasonably impair your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
2. Within the past 5 years, have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition which impaired, or might reasonably be considered to impair, your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
3. Do you currently have, or have you had within the past 5 years, a dependency on or abuse of the use of alcohol or drugs, which impaired, or might reasonably impair, your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
4. Within the past 5 years, have you engaged in the excessive use of alcohol or illegal drugs, or received any in-patient or outpatient or individual therapy/treatment or been hospitalized for alcoholism, or illegal use, or been arrested for a DUI (Driving Under The Influence)?
   ☐Yes ☐No
5. Within the past 5 years, have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .10% BAC? (This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional.)
   ☐Yes ☐No

*****Affidavit of Applicant*****

I hereby state that the information contained in this application is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of certification. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for certification. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice as a physician assistant to any person, institution, association, school, hospital or government entity.

_____

Signature of Applicant

_____

Print Name

Seal of Notary

Subscribed and sworn to before me by the above named applicant this _____ day of _____, 20_____. This application consists of 5 pages.

_____

Signature of Notary

My commission expires: _____

Deadlines For Committee Dates

In order for your application to be presented to the Physician Assistant Advisory Committee, your application must be completed in its entirety and must be on file in the Board office no later than the deadline dates below. Once your application is reviewed by the Advisory Committee, it is then submitted to the Kentucky Board of Medical Licensure for final approval.

Deadline Date	**PA Meeting Date**	**Board Meeting Date**
January 13, 2006	February 2, 2006	March 16, 2006
April 14, 2006	May 4, 2006	June 22, 2006
July 14, 2006	August 3, 2006	September 13, 2006
October 13, 2006	November 2, 2006	December 14, 2006

PHYSICIAN ASSISTANT

REQUEST FOR TEMPORARY CERTIFICATE

Once your application has been completed, if you need to begin working, you may request a temporary certificate. A check for $50.00 must be submitted from the physician assistant (this is part of the $100 required for full certificate), and $100 from the primary supervising physician. The review process for temporary approval takes approximately two to three weeks.

If interested in a temporary certificate, please complete the following:

Name: _____

Supervising Physician Name: _____

Anticipated Starting Date: _____

TEMPORARY CERTIFICATES ARE ONLY VALID FOR <u>UP TO SIX MONTHS</u>

AND CANNOT BE EXTENDED OR RENEWED

Form 1

Release and Waiver of Rights Form

I, _____, hereby authorize the following individuals and entities to release all information (documented, oral or other) about me in their possession to the Kentucky Board of Medical Licensure (KBML) or its agents:

1. All hospitals or other health care facilities at which I have ever held staff privileges, whether full or limited, temporary or permanent; and all hospitals or other health care facilities at which I have ever received training.

2. All physician assistant organizations/societies, specialty boards and other related organizations with which I have been associated.

3. All supervising physicians and their associates with which I have been employed and/or associate.

4. All other state or Canadian licensure boards, federal health agencies, and federal and state drug control agencies.

5. All licensed physicians, nurses, physician assistants or other health care professionals of any state or Canadian province.

6. All schools of educational facilities at which I have ever received training as a physician assistant.

7. All attorneys who have participated in civil or criminal actions in which I am named party.

I hereby release the above-named individuals and entities from all liability for the release of information to the Board (KBML) or its agents.

I further authorize the Board (KBML) or any of its duly authorized agents, to make any investigations that they deem necessary to secure information concerning me which is relevant to the requirements of certification. I further authorize them to release such information they may now or in the future have, concerning me to (i) any federal, state, county or local governmental entity, (ii) any hospital or other health care facility, or (iii) any other person upon a showing that the release of the information is vital to the health, safety and welfare of the general public.

I hereby make this release and waiver of rights for the purpose of allowing the Board (KBML) to carry out its duties pursuant to my request for certification to practice as a physician assistant in the Commonwealth of Kentucky; and further, for the purpose of allowing the Board (KBML) to carry out its duties in regard to my continued certification.

This release and waiver of rights has no expiration date and shall remain effective during my certification in the Commonwealth of Kentucky.

_____ _____

Date Applicant

Sworn to and subscribed before me by the above named applicant on this _____day of _____, 20 ____.

Seal

_____

Notary Public

My Commission expires:_____

Form 2

National Commission of Certification of Physician Assistant Waiver Release Form

Applicant: Complete the top half of this form and return the entire form to the Board with your application.

Name: ____ SS# ______________________
Last First Middle

Address: ____
Street City State Zipcode

I authorize the National Commission on Certification of Physician Assistants to release to the Kentucky Board of Medical Licensure all of the information requested below. I recognize that it is my responsibility to apply for the next available NCCPA examination and failure to apply for the next application deadline will result in termination of my permit.

____
Applicant's Signature

●●

National Commission on Certification of Physician Assistants
Certification of Examination Scores
Primary Care Physician Assistant Examination

As Registrar of the National Commission on Certification of Physician Assistants, I hereby attest that the above named applicant has attempted the Primary Care Physician's Assistant Examination ________ time(s) on the following dates: ____.

____ ________________________
Name of Registrar of NCCPA Date

As Registrar of the National Commission on Certification of Physician Assistant's, I hereby attest that the above names applicant successfully completed the Primary Care Physician's Assistant Examination on the ______ day of _________________________, and that his/her score received was __________. Passing score is ___________.

____ ________________________
Name of Registrar of NCCPA Date

-Or-

I hereby attest that the above named applicant failed to achieve a passing score on the NCCPA examination on the ________day of _______________________.

____ ________________________
Name of Registrar of NCCPA Date

Please return completed form to: Sandy K. Brooks, PA Coordinator, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, KY 40222.

Form 3

Verification of Certification
Physician Assistant

Please complete this section of the form and mail to each state board in which you are now or have been certified. If needed, you may duplicate this form.

As a part of the application for certification as a physician assistant, the Kentucky Board of Medical Licensure requires this form to be completed by each state in which I hold or have ever held certification. I hereby authorize the release of any information in your files, favorable or otherwise to be sent directly to the Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, KY 40222.

____, P.A.-C
Signature

____
Name

____
Address

____
Certificate Number

• •

State of ____________________ Certification/Registration # ________ Issue Date______________________

Full Name of Certificate Holder: ____

Graduate of: ____

By: Endorsement/Reciprocity with ____

By: Your State Board's Written Examination ____

Is Certificate Current? __________________________ If NO, Why? ___________________________________

Has certificate been subject to disciplinary action by your agency? ___________________________________
If YES, please attach copies of any formal orders of your agency and minutes of agency decisions.

Comments, if any ____

Signed : ____

Board Seal

Title: ____

Date: ____

Form 4

Certification of Training

In applying for certification as a Physician Assistant in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by the training institution/school where I obtained a degree, diploma or certificate while training to be a physician assistant. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself, directly to:

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

____
Name

____

____
Address

____
Signature

• •

Certification of Training: (to be completed by the training institution/school where the physician assistant degree was conferred)

This is to certify that ______________________________

Attended the ______________________________

Located at ______________________________

And was granted the degree of ____________ on ______________________.

____
Signature

Seal of institution

____
Title

____
Date

Kentucky Board of Medical Licensure
310 Whittington Parkway,#1B
Louisville, KY 40222
502/429-7150
www.kbml.ky.gov

M E M O R A N D U M

TO: Physician Requesting Supervising Physician Privileges

FROM: Sandy K. Brooks, Physician Assistant Coordinator

RE: Application to Supervise a Physician Assistant

Attached is an initial application to supervise a physician assistant in the Commonwealth of Kentucky as well as a supplemental application to supervise a physician assistant. The supplemental application is required to request additional scope of medical services and procedures not acquired through an approved physician assistant training program.

Please note that only completed applications will be considered by the Kentucky Board of Medical Licensure's Physician Assistant Advisory Committee. Incomplete applications will be returned to the applicant. The fee for approval to supervise a physician assistant is $100.00.

The Committee meets quarterly to review applications and make recommendations to the Kentucky Board of Medical Licensure for final approval. Should you wish to begin employing the physician assistant prior to the Board meeting, there are provisions for temporary certification for supervising the new physician assistant applicant and, tentative approval for supervising the certified physician assistant**.** Please note that temporary certification or tentative approval must be granted prior to the physician assistant providing services under your supervision. The review process for approval takes approximately two to three weeks. The deadline for consideration of an application for the Physician Assistant Advisory Committee is listed below:

Deadline Dates	**Committee Dates**	**Board Meeting Dates**
January 13, 2006	February 2, 2006	March 16, 2006
April 14, 2006	May 4, 2006	June 22, 2006
July 14, 2006	August 3, 2006	September 13, 2006
October 13, 2006	November 2, 2006	December 14, 2006

Should you have any questions regarding the above, please contact me at (502) 429-7150.

Definitions of Levels of Supervision

It is necessary to indicate on the application the level(s) by which you will be supervising a physician assistant.

Direct Supervision: This means the supervising physician is actually in sight of the physician assistant when the physician assistant is performing the function requiring direct supervision. Although the physician may be performing some other task at the time, the supervising physician may immediately provide direction or assume the performance of the task if difficulties arise. This does not require that the physician is watching "over the shoulder" of the physician assistant as would be required during the training period to ensure that the physician assistant is competent to perform the task.

On-site supervision: Requires the physical presence of the supervising physician in the same location (i.e. the physician's office suite) as the physician assistant, but does not require the physical presence in the same room.

Off-site supervision: The supervising physician must be continuously available for direct communication with the physician assistant and must be in a location that, under normal conditions, is not more than 30 minutes travel time from the physician assistant's location.

*****The Board has adopted as policy that a physician assistant be required to have two continuous years of experience before the Board approves off-site supervision. Direct or on-site supervision will be required at all times during a physician assistant's first two years of practice unless a waiver has been requested by a supervising physician and approved by the Board. A primary or alternate supervising physician will have to be, at a minimum, on-site during a physician assistant's work shift during this two-year period.

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Initial Application for Physician to Supervise Physician Assistant
"This Application is in Compliance with the American Disabilities Act"

1. Name of Supervising Physician: _____
(First) (Middle) (Last)

2. Office Address: _____
(Street Address)

_____
(City) (State) (Zipcode)

3. Telephone: (Office) _____ 4. Type of Practice: _____

5. Kentucky Medical License Number: _____ Expiration Date: _____

6. Professional background including membership in medical societies, American Boards, Board eligibility, and or other professional organizations:

_____

_____

7. List hospital staff positions: _____

_____

8. Have you filed application to supervise a physician assistant before? If your answer is YES, list the names of the physician assistants on whom applications to supervise have been previously submitted. ☐ Yes ☐ No

_____

_____

9. The names and address of one or more physicians who will serve as a supervisor for the physician assistant named in this application in the temporary absence of the supervising physician. Pursuant to 311.854, Sec 2[c], enclose a copy of the alternate agreement to supervise.

Name Address KY License Number Specialty

_____

_____

_____

10. Name of physician assistant: KY Certification Number: _____

_____
(First) (Middle) (Last)

11. Briefly describe the nature of your medical practice: _____

_____

_____

(Page 2 - Initial Application For Physician To Supervise Physician Assistant)

12. Briefly describe the physician assistant job duties and scope of medical services and procedures that are being delegated by you and that are also within the physician assistants scope of practice acquired in their approved training program. *(To request additional scope of medical services and procedures not acquired through an approved training program, please submit the **supplemental application form**.)* _____

    _____

    _____

    _____

    _____

13. Check all levels of supervision that apply: ☐ **Direct Supervision** ☐ **On-Site Supervision** ☐ **Off- Site Supervision**
    (See attachment for definitions of levels of supervision.) *A physician assistant shall not practice medicine or osteopathy in a separate location from the supervising physician unless the physician assistant has two continuous years of experience in a non-separate location. The Board may modify or waive the requirement.*

14. Will the physician assistant be employed full-time or part-time? _____
    If part-time, please give an estimate of how many hours. _____

15. Describe the means by which you will maintain a line of communication with the physician assistant when not at the same location: _____

    _____

16. List all locations of your practice in which the physician assistant will be utilized: (Include all offices, clinics, hospitals, nursing homes, etc.) Use a separate sheet, if necessary:

    _____

    _____

17. I maintain a practice primarily within the State of Kentucky: ☐ Yes ☐ No

18. Is the physician assistant currently employed by another supervising physician? If your answer is YES, list names of all other supervising physicians and the approximate hours the physician assistant works with that supervising physician.

    _____

19. Is your Kentucky medical license current and in good standing with the KY Board of Medical Licensure? ☐ Yes ☐ No

20. **I Attest That**:

    A. All job duties and scope of medical services and procedures delegated to the physician assistant are within my scope of practice.

    B. All job duties and scope of medical services and procedures delegated to the physician assistant are appropriate for which the physician assistant has been trained in an approved training program.

    C. I accept responsibility for any care given by the named physician assistant.

    D. I maintain a system to assure that the physician assistant is not practicing beyond the scope of my practice.

    E. I will sign all records rendered by named physician assistant in a timely manner as certification that the physician assistant performed the services as delegated.

F. I will re-evaluate the reliability, accountability, and professional knowledge of named physician assistant two years after the physician assistant's original certification in the state of Kentucky, and every two years thereafter; and based on the re-evaluation recommend or disapprove re-certification to the Board.

G. I will notify the Board within three business days if I cease to supervise or employ the named physician assistant.

Affidavit of Applicant

I, _____ hereby state that I have made an adequate investigation and am of the opinion that the aforementioned physician assistant is possessed of good moral character and is both mentally and physically able to perform as a physician assistant with competence. I further state that as supervising physician, I will exercise control and supervision of the named physician assistant in accordance with the rules of the Kentucky Board of Medical Licensure and retain professional responsibility for the care and treatment of patients he/she sees as directed by me.

State of Kentucky County _____

I, _____ hereby certify under oath that I am the person named in this application to supervise a physician assistant in the Commonwealth of Kentucky; that all statements I have made therein are true and the physician assistant will function under my supervision and responsibility.

_____
Physician's Signature

Subscribed and sworn to before me by the above named applicant on this _____ day of _____,20____.
This application consists of 3 pages.

Seal of Notary

_____
Signature of Notary

My Commission expires:_____

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
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Alternate Supervising Physician Agreement

RE: _____ _____
Name of Physician Assistant Name of Primary Supervising Physician

In Compliance with Kentucky State Statute 311.854 Section 2 (c), I agree to serve as an alternate supervising physician for the above mentioned physician assistant in connection with patients under my care. I further understand that this regulation stipulates I can only supervise two physician assistants at one time. **(The alternate supervising physician, must be a physician other than the primary supervising physician.)**

Physician (s) Name	License Number	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I 've read the above, and agree that these physicians will be alternate supervising physicians in my absence.

_____
Signature of Primary Supervising Physician

Sworn to and subscribed before me by the above name applicant on this _____ day of _____ 20 ___.

_____
Notary

My Commission Expires _____.

FAXES WILL NOT BE ACCEPTED

Revised 6/13/05

Kentucky Board of Medical Licensure

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Louisville, KY 40222
(502) 429-7150
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Supplemental Application Scope of Practice of Physician Assistant

1. Name of Supervising Physician: _____
   (First) (Middle) (Last)

2. Kentucky License Number:_____ Expiration Date: _____

3. Office Address: _____

   _____

4. Telephone (Office) _____ Office Fax _____

5. Name of Physician Assistant _____ KY Certification Number_____

6. Describe the physician assistant's additional scope of medical services and procedures not described in the initial application or previously submitted supplemental applications that are being delegated by you. _____

   _____

   _____

   _____

7. Describe the training and education that prepared the physician assistant for this additional delegated scope of medical services and procedures requested. (Information submitted for an accredited facility regarding this scope of practice can be submitted to fulfill this item.) _____

   _____

   _____

   _____

8. Was this training on-the-job training? ☐ Yes ☐ No

9. Was this education accredited? ☐ Yes ☐ No

10. Describe the setting in which the physician assistant will practice this additional delegated scope of medical services and procedures _____

    _____

    _____

11. Describe the level of supervision for this additional delegated scope of medical services and procedures (direct supervision, on-site supervision, off-site supervision) _____

    _____

12. Has this additional delegated scope of medical services and procedures been approved by an accredited facility duly constituted medical staff? ☐ Yes ☐ No

13. Has this additional delegated scope of medical services and procedures received the blessing of your specialty society for delegation to a physician assistant? ☐ Yes ☐ No

14. **I attest that:**

    A. All additional delegated scope of medical services and procedures are within my scope of practice.

    B. All additional delegated scope of medical services and procedures are appropriate to the physician assistant's education, training and level of competence.

    C. I accept responsibility for any care given by the named physician assistant.

Affidavit of Applicant

I, _____ hereby state that I have made an adequate investigation and am of the opinion that the aforementioned physician assistant is possessed of good moral character and is both mentally and physically able to perform as a physician assistant with competence. I further state that as supervising physician, I will exercise control and supervision of the named physician assistant in accordance with the rules of the Kentucky Board of Medical Licensure and retain professional responsibility for the care and treatment of patients he/she sees as directed by me.

State of Kentucky County_____

I, _____ hereby certify under oath that I am the person named in this application to supervise a physician assistant in the Commonwealth of Kentucky; that all statements I have made therein are true and the physician assistant will function under my supervision and responsibility.

_____
Physician's Signature

Subscribed and sworn to before me by the above named applicant on this _____ day _____,20____.
This application consists of 2 pages.

Seal of Notary

_____
Signature of Notary

My Commission expires:_____